



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0036  
PHONE 208-334-8626  
FAX 208-364-1888

February 6, 2007

FILE COPY

Theresa Dixon, Administrator  
Hospice Alliance Of Idaho, LLC  
444 Hospital Way, Suite 411  
Pocatello, ID 83201

Dear Ms. Dixon:

On **January 25, 2007**, a Complaint Investigation was conducted at Hospice Alliance Of Idaho, Llc. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00002192**

**Allegation #1:** A patient fell and hurt his ribs. The hospice nurse put a pain patch on the patient, even though the caregiver and patient did not want the patch, in addition to his other pain medications. The hospice staff did not tell the caregiver about potential side effects from the patch.

**Findings:** An unannounced visit was made to investigate the complaint. During the investigation, staff were interviewed and medical records were reviewed.

One record contained documentation that the patient fell against an oxygen concentrator and sustained a bruise to the left abdomen. Nursing progress notes dated 11/9/06 stated the patient was in "severe pain". Morphine was given by mouth with some relief. Notes written 11/10/06 indicated the patient was not able to tolerate his breathing treatments and had developed tolerance to his pain medication. The physician was consulted and Fentanyl patches were ordered. Notes stated the caregiver was encouraged to continue giving the oral Morphine for 12 hours, due to the delayed effectiveness of the patch. Notes also documented that education was provided to the caregiver about the medications, including the patch.

The R.N. Case Manager for the patient was interviewed on 1/25/07 at 11:30 AM. He stated the patient and caregiver were "hesitant" to use the pain patch. He said he told them it would only be used during this "crisis" to take care of the pain. He said the patient reminded him he was sensitive to medications and if he did not need it, he did not want it. The R.N. stated he thought the patient needed it because of severe pain. The R.N. stated he educated the caregiver about possible side effects of the patch. He indicated the patient had one episode of vomiting, but had no further nausea or other problems. He said he found out during the next visit that the caregiver took the patch off over the weekend.

Medical records for the other three patients contained pain assessments, physician's orders for pain medication, documentation of effectiveness, and evidence of patient/caregiver education related to medications.

**Conclusion:** Unsubstantiated, lack of sufficient evidence.

No documentation was found to indicate the pain patch was used without the consent of the patient. Documentation indicated education related to medications was provided. No patients' rights issues were identified and no deficiencies were cited.

**Allegation #2:** A bottle of morphine provided by hospice did not have a label on it. The inhaler the nurse brought from his car outdated in 2004 and was not labeled for the patient.

**Findings:** During the unannounced visit, staff were interviewed and medical records were reviewed.

One patient's record contained physician's orders for liquid Morphine and three different inhalers. Documentation indicated the medications were ordered from two different pharmacies.

Two male nurses were interviewed related to the provision of medications. The first nurse, interviewed on 1/25/06 at 10 AM, stated the agency primarily ordered medication from one pharmacy. The second pharmacy the agency frequently used provided unit dose and packaged medications. He stated all medications ordered from and provided by the pharmacies were labeled with the patient's name and all of the other required information. He stated medications in a patient's home were disposed of following the patient's death per policy. He further stated inhalers were for single patient use only.

The second nurse, the patient's Case Manager, was interviewed on 1/25/06 at 11:30 AM. He stated physicians ordered the medications and pharmacies filled the prescriptions. He stated the agency primarily used one pharmacy, however, if a patient ran out of a medication provided by the primary pharmacy during the hours it was closed, the medication would be provided by the other pharmacy.

He stated all medications provided by the pharmacy were labeled with the patient's name and other required information.

Neither nurse indicated they had provided unlabeled or outdated medications to any hospice patient.

**Conclusion:** Unsubstantiated, lack of sufficient evidence.

No evidence was found to indicate agency staff provided patients with medications that were outdated or unlabeled. No pharmaceutical services issues were identified and no deficiencies were cited.

**Allegation #3:** A patient's caregiver needed/asked for respite. Hospice said they would provide it, but never did.

**Findings:** During the investigation, medical records were reviewed and staff were interviewed.

One patient's record contained nursing progress notes, dated 8/22/06, indicating the caregiver planned a trip to Arizona to see her mother. The patient/caregiver were advised to call the agency for anticipated increased needs or care. No request for respite was documented.

Documentation on 8/28/06 indicated the caregiver was not going out of town, rather her mother was coming to visit her. No other documentation was found in the record to indicate respite services were needed or requested.

The patient's R.N. Case Manager was interviewed on 1/25/06 at 11:30 AM. He stated respite services were discussed with each hospice patient and their caregiver as part of the introduction to hospice services. The nurse stated to his knowledge, the patient's caregiver had not requested respite.

The agency's social worker was interviewed on 1/25/06 at 11:50 AM. She stated she and the patient talked about respite services. She stated the patient said "no". The patient stated he did not need 24 hour around-the-clock care and wanted to stay alone. She indicated no request for respite care was made by the caregiver.

**Conclusion:** Unsubstantiated, lack of sufficient evidence.

No evidence was found to indicate respite care was requested or denied. No deficiencies were cited.

Theresa Dixon, Administrator  
February 6, 2007  
Page 4 of 4

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in cursive script, appearing to read "Penny Salow".

PENNY SALOW  
Facility Surveyor  
Non-Long Term Care

A handwritten signature in cursive script, appearing to read "Sylvia Creswell".

SYLVIA CRESWELL  
Supervisor  
Non-Long Term Care

PS/mlw



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February 6, 2007

FILE COPY

Theresa Dixon  
Hospice Alliance of Idaho  
444 Hospital Way Suite 411  
Pocatello, ID 83201

Dear Ms. Dixon:

This is to advise you of the findings of the Medicare complaint survey, which was concluded at your facility on January 25, 2007.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.
2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
3. Identify the date each deficiency has been, or will be, corrected.
4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **February 20, 2007**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,



PENNY SALOW  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Supervisor  
Non-Long Term Care

PS/mlw

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/05/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  131543	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 01/25/2007
NAME OF PROVIDER OR SUPPLIER  HOSPICE ALLIANCE OF IDAHO, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 444 HOSPITAL WAY SUITE 411 POCATELLO, ID 83201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
L 000	INITIAL COMMENTS  The following deficiency was cited during a Medicare complaint survey of your hospice agency. The surveyors conducting the Medicare complaint survey were:  Penny Salow, R.N., H.F.S., Team Leader Rae Jean McPhillips, R.N., H.F.S.	L 000	<p style="text-align: center;">RECEIVED FEB 16 2007 FACILITY STANDARDS</p> <ul style="list-style-type: none"> <li>On-Call logs are to be turned in on the next business day on a daily basis to the Office manager for review, and then are to be placed in the on-call log book.</li> <li>Logs for On-Call records will be reviewed weekly by the Branch Director to ensure compliance.</li> <li>Telephone conversation notes are to be turned in with time sheets and notes for review by the Branch Director, then Filed in the patient's chart.</li> <li>Staff education was provided to all staff in a mandatory In-Service on 02/08/2007 re: above expectations and requirements.</li> <li>Case Managers and the IDT have also received review of requirements and expectations for On-Call time.</li> <li>All patient records will contain appropriate documented of all services and events provided by all disciplines. They will be reviewed every 7 days and filed on the charts.</li> </ul> <p><i>2/22/07 1:35pm - compliance date is 3/9/07 as per Marla Cheezman Rm McPhillips</i></p>		
L 185	418.74(a)(6) CONTENT  Each individual's clinical record contains complete documentation of all services and events (including evaluations, treatments, progress notes, etc.).  This STANDARD is not met as evidenced by: Based on staff interview and review of clinical records, it was determined the hospice failed to ensure clinical records for 1 of 4 patients (#2), whose records were reviewed, contained complete documentation of all services and events. This resulted in a lack of communication between on-call staff and primary care staff. The findings include:  1. Patient #2, a 50 year old male, was admitted to hospice services on 7/21/06, with a diagnosis of end-stage chronic obstructive pulmonary disease. The record indicated the patient fell on 11/8/06, resulting in a bruise on his left rib cage. On 11/9/06, nursing visit notes stated the patient was in severe pain and was given liquid Morphine. Nurses' visit notes, written 11/10/06, indicated the patient was still having pain related to the fall. Medication changes were ordered including a Fentanyl patch. Nursing visit notes on 11/13/06, indicated the patient/caregiver were not satisfied with "weekend on-call" and wanted to change hospice providers. No documentation	L 185			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

*Jessie Deaton RN Administrator* 02-15-07

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  HOSPICE ALLIANCE OF IDAHO, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 444 HOSPITAL WAY SUITE 411 POCATELLO, ID 83201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
L 185	<p>Continued From page 1</p> <p>was found in the record to indicate the patient had received services on the weekend from the on-call hospice nurse.</p> <p>2. Patient #2's R.N. Case Manager was interviewed on 1/25/06 at 11:30 AM. He stated that when he made the visit on 11/13/06, the patient/caregiver told him they were dissatisfied with the weekend on-call. They also told him they discontinued the Fentanyl patch over the weekend. They said the patient had vomited once, a single episode and had no further nausea. The patient/caregiver told him they wanted to discontinue hospice services with them. The R.N. Case Manager did not know where the on-call contact had been documented.</p> <p>3. The R.N. Branch Manager was interviewed on 1/25/07 at 1:30 PM about the missing documentation in Patient #2's record. After checking the calendar and the on-call log, the Manager determined she had been on call that weekend. She remembered taking a call about the patient's pain. She stated she instructed the caregiver to administer the Morphine and to let her know if it was effective. She stated she did not receive a call back from the caregiver, so she called the caregiver on Sunday. The caregiver told her the patient had finally slept, better than he had in days. The Manager reviewed the file and confirmed she had not documented the patient/caregiver contact.</p>	L 185			

*Leresa Devoe* RN, Administrator  
2/15/07